STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455940	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lubbock Hospitality Nursing and Rehabilitation Cen	4710 Slide Rd Lubbock, TX 79414

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on observation, interview and record review, the facility failed to ensure the rights of the residents to be free from abuse and neglect for 3 of 6 residents (Resident #1, #2, and #3) reviewed for abuse A. The facility failed to keep Resident #2 safe from abuse when Resident #1 pulled her out of bed after already exhibiting increased aggressive behavior on 11/14/24. B. The facility failed to keep Resident #3 safe from abuse when Resident #1 grabbed her in the face after already exhibiting increased aggressive behavior on 11/14/24. C. The facility failed to keep Resident #1 safe from an unknown nighttime staff when allegations of abuse was made on 11/23/24 by Resident #1 and Family Member M to CNA A, C, the Assistant Activity Director, LVN B and a confidential individual. An Immediate Jeopardy (IJ) was identified on 11/27/24 at 12:49 PM. The IJ template was provided to the facility on [DATE] at 12:49 PM. While the IJ was removed on 11/27/24 at 1:28 PM, the facility remained out of compliance at a severity level of actual harm and a scope of pattern because all staff had not been trained on 11/27/24. This failure could place residents at risk for serious psychosocial harm from abuse, humiliation, intimidation, fear, shame, agitation, and decreased quality of life. Findings included: Resident #1 Record Review of Resident #1's face sheet, dated 11/22/24, revealed an [AGE] year-old male that was admitted to the facility on [DATE], with a diagnosis of dementia (memory loss). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review of Resident #1's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 00, indicating the resident was severely cognitively impaired. Section E revealed Resident #1 exhibited physical behavior (hitting, kicking, pushing, scratching, grabbing, and abusing) during the review [E0200]. The identified symptoms placed the resident at significant risk for physical illness or injury [E0500]. The identified symptoms placed others at risk for physical injury, significantly intruded on the privacy or activity of others, and significantly disrupted care or living environment. Record review of Resident #1's progress notes dated from 09/22/24- 11/22/24 revealed the following: The Social Worker documented on 11/14/24 at 6:35 PM that she received a message from staff (unidentified) that a staff (unidentified) was punched in the face. LVN N documented on 11/14/24 at 8:30 PM that Resident #1 hit the day certified nursing aide (unidentified) in the face and opened a skin tear on both arms. LVN N documented on 11/14/24 at 8:40 PM that Resident #1 was becoming agitated again, hit a certified nursing aide (unidentified) in the chest. Resident #1 was pacing and yelling in intervals. Record review of Resident #1's care plan, dated 11/22/24, revealed a focused area, initiated on 11/22/24, Resident #1 had a history of aggressive behavior towards others. The goal initiated on 11/22/24, was Resident #1 would have fewer than 3 episodes of aggressive behavior before the next review date. The interventions initiated 11/22/24 included keeping the environment calm, relaxed, convey acceptance of the resident during periods of inappropriate behavior, remove from public area when behavior was unacceptable, and to ask for help when his behavior becomes unacceptable. Record review of the facility event summary report, dated 08/26/24-11/26/24, revealed the following: Resident #1 had aggressive/combative resident-to-resident aggression on 11/16/24 and 2 unwitnessed falls on 11/23/24. Record review of the facility event summary report dated 08/26/24-11/26/24, did not reveal any documentation regarding his resident-to-resident altercation that occurred on 11/14/24 with Resident # 2 and Resident #3. Record review of Resident #1's hospice progress notes did not reveal any information about Resident #1's and Family Member B's allegation of ANE. There was no information regarding Resident #1's resident-to-resident altercation with Resident #2 (pulling her out if bed). There was no information regarding Resident #1's resident-to-resident altercation with Resident # (grabbing her in her face). The notes did reveal the following: On 11/23/24 at 5:39 AM a call was placed by LVN N to hospice requesting a nurse visit. The progress note indicated that LVN N stated Resident #1 rolled out of bed and had an abrasion to his right eyebrow, a cut on his lip and a skin tear to the bridge of his nose. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/23/24 Hospice Nurse T assessed Resident #1. Hospice Nurse T observed Resident #1's nose and lower swollen. She observed steri strips to the face and nose. State surveyor attempted to interview LVN N on 11/27/24 at 8:34 AM and the attempt was unsuccessful. State surveyor left a message. During an interview on 11/26/24 at 9:30 AM, the Regional Nursing Consultant stated during the entrance conference that an injury of unknown origin or bruising should be investigated and reported to HHSC. She said if the bruising could be explained, a progress note would be entered by the nurse who identified the bruising and explain where the bruising came from. She said all efforts would be documented in the resident's electronic medical record. During an interview on 11/26/24 at 10:00 AM, Family Member M stated she was told by facility staff that Resident #1 had told them a nighttime staff had hit him the weekend off 11/23/24 and that she was notified that Resident #1 had a fall. She said she did not know the full name of the staff who reported this information to her nor did she know the name of the staff that allegedly hit Resident #1. She said Resident #1 told her that a woman had hit him. She said the same staff reported that another female resident had hit Resident #1. She said she did not tell anyone specifically about what the facility staff and Resident #1 told her, but that staff knew because she (Family Member M) was vocal about it. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A confidential interview revealed that Resident #1 had a fall the weekend of 11/23/24. They said they could not remember if it was a Friday or a Saturday. They said when they came to work, Resident #1 was quiet and not as active as he once was. They said that Resident #1 gestured with his hand that staff had hit him on top of the head. They asked Resident #1 if it was an overnight staff that had hit him, and Resident #1 stopped answering questions when they started asking for details. They stated Family Member M had expressed in the past that she did not feel that the overnight staff were taking care of Resident #1. They said the weekend that they came in for their shift, and Resident #3 allegedly fell he (Resident #1) did have a cut on his eye and his lip. They said when they attempted to get Resident #1 up for breakfast, Resident #1 was sleepy, and she had to get a wheelchair to roll him to the table. They said they did not know if this was from the fall. They stated that the morning Resident #1 fell , a hospice nurse (unknown) and LVN B were assessing Resident #1. They said the hospice nurse (unknown) said the injuries that Resident #1 sustained were not consistent with a fall. They said that the hospice nurse (unknown) did not say what specifically the injuries looked like they came from. They stated that the same day, Resident #1 did not eat. They said when Resident #1 told them that he had been hit by staff, they told CNA A. They said CNA A told them the injuries looked like injuries from a fall, and CNA compared Resident #1 to another resident with a similar fall. They said that Family Member M told them that Resident #1 had expressed to her that he had been hit by night staff. They said that they did not report the allegations that Resident #1 reported to them nor the concerns that Family Member M reported to them because their phone was not working. They stated they did not use the facility phone because the on-call staff never answered the phone when they called from the facility phone. They said the previous day, they had tried to call the on-call phone from the facility for a staffing concern, and the staff did not answer. They said they had been trained to call the ADM, who was the abuse coordinator if they witnessed or suspected ANE. They said they had been taught to contact the abuse coordinator immediately. They said that they did not contact the ADM, who was the abuse coordinator, because it was the weekend. They said they could not remember if they reported the allegations of ANE to LVN B, but the nurse typically does not stay in the locked unit. They said they did mention the accusations of ANE regarding Resident #1 to the Assistant Activity Director. They said no one had asked them anything about the nature of the fall. During an interview on 11/26/24 at 3:06 PM, CNA A stated that she did not know much about the fall that occurred on 11/23/24 involving Resident #1. They said CNA O told her that Resident #1 had an unwitnessed fall when she came on shift. She said CNA O told her that LVN N was helping her do rounds and change residents. She said CNA O said that she and LVN N had come out of Resident #1's room, and he had fallen. CNA A said she did not remember a staff member telling her that Family Member M had concerns about the injuries, but that Family Member M did express to her that she had concerns about the injuries that Resident #1 sustained. CNA A said that when Family Member M said that she did not think the injuries were consistent with a fall, she encouraged Family Member M to talk to LVN B because as a certified nurse aide she had been trained to refer family concerns to her nurse. CNA A said Resident #1's face was beat up. She said Resident #1 had steri-strips (reinforces skin closure) all over his face. She said he had a busted lip and a cut by his eye. CNA A said she was unaware of Resident #1 having any physical altercations with female residents where he was not the aggressor. CNA A said Resident #1 was aggressive, and all staff knew about it, which had been reported to management. CNA A said Resident #1 had punched her in the face. She said she could not remember the exact date but that it was documented in Resident #1's progress notes. She said they did not receive any instructions on handling Resident #1. She said she felt if his behaviors had been addressed, his behaviors wouldn't have continued to escalate. She said no one had interviewed her regarding Resident #1's behaviors or Family Member M's allegations. CNA said that she had been trained to report ANE as soon as possible to the ADM. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/26/24 at 3:55 PM, the Assistant Activity Director stated that she had experience with Resident #1 and his aggressive behavior. She said when Resident #1 had his resident-to-resident altercation on 11/16/24, she was assisting taking him out of the memory unit to calm down. She said Resident #1 saw an exit door and attempted to exit. She said she tried to redirect him, but he grabbed her hair and pulled it. She said they ultimately got him back to the unit. She said that Resident #1 punched another staff member in the face before that incident. She said she had not received any training specific to Resident #1 on responding to his aggressive behaviors. She said on Saturday, 11/23/24, she went into the memory unit and noticed Resident #1 was at the dining room table with his head down. She thought this was odd because Resident #1 was usually up and pacing around. She said CNA P told her that Resident #1 had fallen. She said she had asked if Family Member M had been notified and was told that attempts had been made, but they were unsuccessful because Family Member M's phone was off. The Assistant Activity Director said that later in the day (11/23/24), Family Member M came to the facility and said to her that Resident #1 reported to her (Family Member M) that someone came into his room at night and hit him. She said it was around lunchtime when she (Family Member M) told her that Resident #1 made the allegation. The Assistant Activity Director stated she told the aides (she did not disclose who) that were working the memory unit and that the aides said that it looked like someone hit Resident #1. She said she told the aides to get a nurse to explain Resident #1's injuries to Family Member M. She said the nurse (LVN B) told Family Member M it was a fall, and it was documented. The Assistant Activity Director told LVN B that Family Member M thought someone had beaten Resident #1 up. She was told that the documentation reflected that Resident #1 had a fall. The Assistant Activity Director said the abuse coordinator was the SW. She said she did not report the allegations of abuse to the SW because the SW was not at the facility. She said she had been trained on what to do if they suspect or witnessed abuse. She said that she had been taught to call the ADM. She said that she did not report the allegations of ANE to the ADM because she was not there when the incident allegedly happened. She said no one had interviewed her to ask her about her knowledge of the incident regarding allegations of abuse. She said she was unaware of any physical altercations that involved Resident #1. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/26/24 at 8:20 PM, LVN B stated the abuse coordinator was the ADM. She stated she had ANE training. She said she had been trained that if she witnessed or suspected abuse, she needed to report the allegation to the ADM as soon as possible. She said that on the day (11/23/24), Resident #1 fell on the overnight shift. He had also fallen on her shift (a day shift). She said CNA A said that she had found Resident #1 on the floor. She said she assessed Resident #1 and called Hospice out for assistance. She said she notified Family Member M. Family Member M was upset because Resident #1 had fallen on the overnight shift. LVN B said it was around 1:00 PM when Resident #1 had fallen on her shift. LVN B said she did not have details about Resident #1's first fall. She said Family Member M was upset. She said that she could tell by her body language but that she was speaking in Spanish to CNA A. LVN B said it was relayed to her from CNA A that Family Member M did not believe the lacerations, cuts, and gashes had come from a fall and that he looked like he had been punched. She said Resident #1 had a history of falls. LVN B said she did not report the allegations that CNA A had translated from Family Member B to the ADM because Family Member B was concerned with the overnight fall. She (LVN B) was sure that Resident #1 did not get punched on her shift, and that Family Member M said she would take Resident #1 home. She said that she was told that Resident #1 had a history of falls, according to the hospice nurse who came out and was not sure why Resident #1's falling was an issue. LVN B said she was unaware that Resident #1 had any physical altercations with female residents in the locked unit. She said Resident #1 never said he had been hit by staff when she interacted with him. She said she was unaware of any incidents that involved Resident #1 and other female residents. She said that since his admission, she had never received any training on how to deal with Resident #1's aggressive behavior. She said she had never been interviewed regarding Resident #1's behaviors or the allegations of ANE. She said the potential negative outcome of not reporting allegations of ANE to the abuse coordinator was that the abuse could continue. She said Resident #1 had told her that he fell . She said she documented what happened during her shift but did not document the information regarding Family Member M because she knew no one punched Resident #1 on her shift. She said that although it may sound silly, she felt that Family Member M wanted to take Resident #1. During an interview on 11/26/24 at 8:25 AM, Hospice Nurse S did not provide any information that supports the facility's deficient practice. She reported that she did not have any concerns with staff treatment, nor did she suspect or witness ANE. She was unaware of any allegations that Family Member M made. She said that she was the nurse who came out when he had behaviors on 11/14/24. She said there were discussions to send him to a behavioral center, but it was decided and, in her opinion, not beneficial for Resident #1 because of his diagnosis of dementia. She said she never said that his injuries were inconsistent with a fall. During an interview on 11/26/24 at 8:38 AM, Hospice Nurse T did not provide any information that supports the facility's deficient practice. She reported that she did not have any concerns with staff treatment, nor did she suspect or witness ANE. She was unaware of any allegations that Family Member M made. She said she came out on 11/23/24 when Resident #1 had his 2nd fall; this was her first time meeting Resident #1. She said that she never expressed that she felt that Resident #1's injuries were inconsistent with any of his falls. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/27/24 at 9:30 AM, CNA C stated that she did not know any details about Resident #1's fall on 11/23/24. She said she heard about Resident #1 punching CNA A but knew nothing about that incident. She said she knew that Resident #1 had been aggressive since he came to the facility. She said she heard that Resident #1 had a broken nose and that someone had been hitting him on top of the head. She said she heard it was a nighttime staff that was hitting him. She said she was told this on 11/26/24 by CNA A. She said she did not report what CNA A told her to the abuse coordinator because she was told that it had already been reported to the state. She said she had no proof that the allegation of ANE had been reported but was told that was why the state was in the facility. She said she had been trained that all allegations of abuse should be reported to the abuse coordinator as soon as possible. She said she received abuse training within the last year when she took her CNA classes. She said the potential negative outcome of not reporting allegations of abuse could allow abuse to continue. During an interview on 11/27/24 at 9:23 AM, the ADM stated he was unaware of Family Member M's allegations of abuse. He said none of the incidents were investigated because he was unaware of the incidents. Preventive measures were not put in place to protect Resident #1 after the allegations of abuse because he was unaware of the incident. He was unaware that Resident #1 had aggressive behaviors before admission. He said that there were discussions about sending Resident #1 to a behavior facility, but after consulting with Hospice, it was recommended by Hospice that pharmaceutical attempts should be taken first. Regarding the injury of unknown origin, he said he was unaware of the injury and that the staff did not know where it came from. He said this was not reported to him. Resident #2 Record Review of Resident #2's face sheet, dated 11/27/24, revealed an [AGE] year-old female that was initially admitted to the facility on [DATE] and readmitted on [DATE], with the following diagnoses: dementia (memory loss), anxiety (increased worry), and cognitive communication (difficulty communicating). Record Review of Resident #2's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score was blank. Section E did not reveal any documented behaviors for Resident #2. Record Review of Resident #2's Brief Interview for Mental Status (BIMS) dated 11/27/24 revealed the summary score was 99, indicating the resident was severely cognitively impaired. Record Review of Resident #2's Quarterly MDS assessment dated [DATE], revealed under Section E did not reveal any documented behaviors for Resident #2. Record review of Resident #2's care plan, dated 08/22/24, revealed a focused area, initiated on 10/01/24, that indicated Resident #2 had socially inappropriate/disruptive behaviors as evidenced by abusing the staff. The goal initiated on 10/31/24, Resident #2 will not harm self or others. The interventions initiated 10/01/24 included assessing the resident for placement, assess whether the behavior endangers the resident and others, avoid over stimulation, praise for acceptable behavior, and maintain a calm environment. Record review of Resident #2's progress notes dated from 08/27/24- 11/27/24 did not reveal any information regarding her resident-to-resident altercation on 11/14/24 with Resident #1. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility event summary report dated 08/26/24-11/26/24, did not reveal any documentation regarding his resident-to-resident altercation that occurred on 11/14/24 with Resident #2 and Resident #1. Record review of Resident #2 EMR did not reveal any assessments conducted on 11/4/24. During an interview on 11/26/24 at 9:07 AM Family Member R stated they did not have any concerns with the treatment of Resident #2. She said she did not get to visit often. She said that she has not received any notifications of ANE. She said she only received notification when Resident #2 had fallen or if they had sent Resident #2 out to the hospital. She said no incidents involving Resident #2 and any of her peers had been reported to her. During an interview on 11/26/24 at 3:06 PM, CNA A stated she had been trained on what to do if she suspected or witnessed abuse. She stated she had been instructed to report all allegations of ANE to the ADM, who was the abuse coordinator, as soon as she suspected or witnessed abuse CNA A said she was unaware of Resident #1 having any physical altercations with female residents where he was not the aggressor. CNA A said Resident #1 was aggressive, and all staff knew about it, which had been reported to management. CNA A said Resident #1 had punched her in the face. She said she could not remember the exact date but that it was documented in Resident #1's progress notes. She said on the same day he punched her in the face, Resident #1 had increased behaviors. She said she heard Resident #2 yelling. When she walked into Resident #2's room, she observed Resident #1 attempting to pull Resident #2 out of bed. She said Resident #2's bed was lowered to the floor with a bedside mat next to it. She said she observed Resident #1 standing on the mat next to Resident #2's bed, and he had her by her (Resident #2's) legs. CNA said that Resident #2 was screaming, and Resident #1 was accusing them (staff) of restraining Resident #2 and that he would call the police. CNA A said she attempted to redirect Resident #1, but he tried to hit her. She said she blocked the first hit from Resident #1. She said he then tried to grab the fire extinguisher and said he would hit her. She said Resident #1 grabbed a chair, and because other residents were close, she went to grab the chair from him. She said that when she got the chair from him, and she was putting it down, Resident #1 hit her hard in the face, and she started crying. She said that on the same date that Resident #1 hit her he also tried to pull Resident #2 out of bed. She said the Former DON wanted to send Resident #1 to a behavior center but was told by the ADM that they wanted to try other things. She said she told the ADM that Resident #1 and the other residents in the locked unit were not safe. She said she did tell the ADM about Resident #1 hitting her and pulling Resident #2 out of bed. CNA A said she was unsure if a nurse physically assessed any of the residents because she was told to go home and leave. She said they did not receive any instructions on handling Resident #1. She said she felt if his behaviors had been addressed, his behaviors wouldn't have continued to escalate. She said no one had interviewed her regarding Resident #1's behaviors or his interactions with Resident #2. She said she was alone in the memory unit during the time the incident occurred. During an interview on 11/26/24 at 4:30 PM, the SW stated she was not present when Resident #1 grabbed Resident #3 in the face. She said that she was notified by staff but did not remember the staff who reported the information. She stated she had never observed Resident #1 grab anyone but had observed Resident #1 being redirected. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/27/24 at 9:30 AM, CNA C stated that she said she knew that Resident #1 had been aggressive since he came to the facility. She said she did not see the incident but had heard about Resident #1 trying to pull Resident #2 out of bed because he thought she (Resident #2) shouldn't have been in bed. She was unsure of the date of the incident. CNA C said she was unaware if Resident #1 actually made contact with Resident #2. She said no one ever interviewed or asked about the resident-to-resident altercation between Resident #1 and Resident #2. During an interview on 11/27/24 at 9:23 AM, the ADM stated he was unaware of an incident where Resident #1 tried to pull Resident #2 out of bed. He said none of the incidents were investigated because he was unaware of the incidents. He said no preventative measures were put in place to safeguard Resident #2 from Resident #1. During an interview on 11/27/24 at 1:05 PM, Resident #2 was unable to answer any questions about the alleged incident between her and Resident #1. She turned her head and refused to speak. Resident #3 Record Review of Resident #3's face sheet, dated 11/27/24, revealed an [AGE] year-old female that was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of dementia (memory loss), anxiety (increased worry), and cognitive communication deficit (difficulty communicating). Record Review of Resident #3's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 03, indicating the resident was severely cognitively impaired. Section E did not reveal any documented behaviors for Resident #3. Record Review of Resident #3's Quarterly MDS assessment dated [DATE], revealed under Section E did not reveal any documented behaviors for Resident #3. Record review of Resident #3's progress notes dated from 08/27/24- 11/27/24 did not reveal any information regarding her resident-to-resident altercation on 11/14/24 with Resident #1. Record review of Resident #3's care plan, dated 06/12/24, revealed a focused area, initiated on 10/01/24, Resident #3 had physically abusive behavior symptoms. The goal initiated on 11/06/24, was Resident #3 would not physically abuse other residents, visitors, and staff. The interventions initiated 10/01/24 included assess whether the resident's behavior endangers the resident or others, convey an attitude of acceptance towards the resident, maintain a calm environment, and allow extra time to process information. Record review of the facility event summary report dated 08/26/24-11/26/24, did not reveal any documentation regarding his resident-to-resident altercation that occurred on 11/14/24 with Resident #1. Record review of Resident #3 EMR did not reveal that any assessments were conducted on 11/14/24. (continued on next page)

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	455940	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lubbock Hospitality Nursing and Rehabilitation Cen	4710 Slide Rd Lubbock, TX 79414

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/26/24 at 3:06 PM, CNA A stated Resident #1 had punched her in the face. She said she could not remember the exact date but that it was documented in Resident #1's progress notes. She said on the same day he punched her in the face, Resident #1 had increased behaviors. She said that on the same date that Resident #1 hit her in the face, he grabbed Resident #3 in the face. She said the ADM and the SW were present when Resident #1 grabbed Resident #3 in the face. She said Resident #1 did it so fast that she could not intervene. She said Resident #3 exclaimed, Why did he do that? She said the Former DON wanted to send Resident #1 to a behavior center but was told by the ADM that they wanted to try other things. She said she told the ADM that Resident #1 and the other residents in the locked unit were not safe. She said she did not tell the ADM about Resident #1 grabbing Resident #3 in the face because he was present when Resident #1 grabbed Resident #3 in the face. CNA A said she was unsure if a nurse physically assessed any of the residents because she was told to go home and leave. She said they did not receive any instructions on handling Resident #1. She said she felt if his behaviors had been addressed, his behaviors wouldn't have continued to escalate. She said no one had interviewed her regarding Resident #1's behaviors or his interaction with Resident #3. CNA A said that she was the only staff in the memory unit when the incidents occurred. During an interview on 11/27/24 at 9:23 AM, the ADM stated he said he was unaware of an incident where Resident #1 grabbed Resident #3 in the face. He said none of the incidents were investigated because he was unaware of the incidents. He said no preventative measures were put in place to safeguard Resident #3 from Resident #1. During an interview on 11/27/24 at 1:17 PM, Resident #3 stated she could not remember the date or the name of the male resident who grabbed her in the face. She said it hurt. She said that the male resident was no longer in the facility, and she was glad because him grabbing her scared her. She said she did not know why he grabbed her, but he was mean. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/27/24 at 9:23 AM, the ADM stated that regarding resident-to-resident altercations, he expected staff to separate them and ensure the residents were calm and safe. He said they should immediately notify the abuse coordinator. He said the potential negative outcome is that if steps were missed or done out of order, something could happen to the residents or escalate the incidents. He said not reporting resident-to-resident altercations or handling them appropriately could cause an inability for barriers and interventions to be put in place to protect residents. He said if an incident occurs on the weekend, the staff should respond the same. He said there was an on-call system that staff have been trained to use, but unfortunately, the phone was with a staff that no longer worked at the facility. He said the on-call telephone had just been returned to the facility on [DATE]. He said his phone number was posted everywhere, so staff still should be able to reach him, and he would answer phone calls from the facility. He said staff have been trained to send a text and to keep calling if they do not get an answer. He said he had no documentation to reflect the staff training to keep calling if they do not get an answer. He said he verbalized this in ANE training. He said if there was an allegation of ANE, notifications should be made to the physician, abuse coordinator, and the police if actual abuse occurred. He said the potential negative outcome of not following the abuse policy could be that interventions could not be put in place to protect the residents and prevent abuse. He said residents should be assessed by a nurse for mental concerns and physical injuries. He said if residents were not assessed, there could be an untreated mental concern or untreated issue. He said that an investigation should be conducted if there were abuse allegations. He said the failure to conduct investigations of ANE could prevent them from knowing how something occurred and what occurred and hurt the ability to prevent abuse from happening again. He said prevention measures should be put in place. He said that the aggressor should be monitored depending on the situation and that no additional aggressive behavior should be allowed. He said he was the abuse coordinator, and all things (allegations of ANE and resident-to-resident altercations) should be reported to him within an hour or as soon as possible. He said allegations of abuse, resident-to-resident altercations, assessments, and notifications to the family should be documented. He said the nurse working on the incident would be responsible for documentation, assessments, and notifications. He said he, as the abuse coordinator, was responsible for investigating and reporting to HHSC. On 11/27/24 at 12:49 PM an IJ situation was identified due to the above failures and the IJ template was provided. The following Plan of Removal submitted by the facility was accepted on 11/27/24 at 2:30 PM: Plan of Removal: F607: Develop/Implement Abuse/Neglect, etc. Policies 1. Immediate A [TRUNCATED]

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on interviews and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse and neglect for 3 of 6 residents (Resident #1, #2, and #3) reviewed for abuse. A. The ADM failed to follow the facility's abuse policy by not reporting the allegation of abuse to HHSC and documenting his investigation/prevention measures regarding Resident #1 by an unknown nighttime staff on 11/23/24 . CNA A, C, the Assistant Activity Director, LVN B, and a confidential individual failed to follow the facility's abuse policy by not reporting the allegation of abuse involving Resident #1, reported by Resident #1 and Family Member M on 11/23/24 to the abuse preventionist between the dates of 11/23/24-11/27/24. B. The ADM failed to follow the facility's abuse policy by not reporting the incident to HHSC and investigating an injury of an unknown origin involving Resident #1 that occurred and that was documented on 11/11/24. C. The ADM failed to follow the facility's abuse policy by not reporting the resident-to-resident altercation (Resident #1 attempted to pull Resident #2 out of bed) that occurred on 11/14/24 between Resident #1 and Resident #2 to HHSC and documenting his investigation/prevention measures regarding Resident #2. D. The ADM failed to follow the facility's abuse policy by not notifying Family Member R of the resident-to-resident altercation (Resident #1 attempted to pull Resident #2 out of bed) that occurred on 11/14/24 between Resident #1 and Resident #2. E. The ADM failed to follow the facility's abuse policy by not assessing Resident #2 for mental and physical effect after the resident-to-resident altercation (Resident #1 attempted to pull Resident #2 out of bed) that occurred on 11/14/24 between Resident #1 and Resident #2. F. The ADM failed to follow the facility's abuse policy by not reporting the resident-to-resident altercation (Resident #1 grabbed Resident #3 in the face) that occurred on 11/14/24 between Resident #1 and Resident #3 to HHSC and documenting his investigation/prevention measures regarding Resident #3. G. The ADM failed to follow the facility's abuse policy by not assessing Resident #3 for mental and physical effect after the resident-to-resident altercation (Resident #1 grabbed Resident #3 in the face) that occurred on 11/14/24 between Resident #1 and Resident #3. An Immediate Jeopardy (IJ) was identified on 11/27/24 at 12:49 PM. The IJ template was provided to the facility on [DATE] at 12:49 PM. While the IJ was removed on 11/27/24 at 1:28 PM, the facility remained out of compliance at a severity level of actual harm and a scope of pattern because all staff had not been trained on 11/27/24. These failures could place residents as risk for abuse and neglect. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Findings included: Record review of the facility policy, Abuse Investigation and Reporting, revised October 2023 revealed: Policy Statement The facility will provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. Policy Interpretation and Implementation The facility will develop and implement written policies and procedures that: o Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; and o Establish policies and procedures to investigate any such allegations; and The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. The facility will provide ongoing oversight and supervision of staff to ensure that its policies are implemented as written. Abuse Prohibition Plan Components II. Prevention of Abuse, Neglect and Exploitation The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; C. Ensuring an assessment of the resources needed to provide care and services to all residents is included in the facility assessment; G. Addressing features of the physical environment that may make abuse, neglect, exploitation, and misappropriation of resident property more likely to occur; and H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	III. Identification of Abuse, Neglect and Exploitation The facility will have written procedures to assist staff in identifying the different types of abuse - mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations. Possible indicators of abuse include, but are not limited to: 1. Resident, staff, or family report of abuse; 2. Physical marks such as bruises or patterned appearances such as a handprint, belt, or ring mark on a resident's body; 3. Physical injury of a resident, of unknown source; IV. Investigation of Alleged Abuse, Neglect and Exploitation An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include: o Identifying staff responsible for the investigation; o Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); o Investigating different types of alleged violations; o Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; o Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and o Providing complete and thorough documentation of the investigation. V. Protection of Resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: Responding immediately to protect the alleged victim and integrity of the investigation; Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Increased supervision of the alleged victim and residents; Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; Protection from retaliation; VI. Reporting/Response The facility will have written procedures that include: o Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 5. Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following: Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences; Defining how care provision will be changed and/or improved to protect residents receiving services; Training of staff on changes made and demonstration of staff competency after training is implemented; Identification of staff responsible for implementation of corrective actions; The expected date for implementation; and Identification of staff responsible for monitoring the implementation of the plan. B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. Management 1. The resident and family/representatives will be informed of the resident's condition as well as the potential risks and benefits or proposed interventions. 2. Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others. Record review of the facility policy, Resident-to Resident Altercations, revised October 2023 revealed: Policy Statement All altercations, including those that may represent resident-to-resident abuse, shall be investigated, and reported to the Nursing Supervisor, the Director of Nursing Services and to the Administrator. Policy Interpretation and Implementation Facility staff will monitor residents for aggressive/inappropriate behavior towards other residents, family members, visitors, or to the staff. Occurrences of such incidents shall be promptly reported to the Nurse Supervisor, Director of Nursing Services, and to the Administrator. If two residents are involved in an altercation, the nursing staff will: a. Separate the residents, and institute measures to calm the situation up to and/or including 1:1 supervision of the offending resident; Identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation; Review the events with the Nursing Supervisor and Director of Nursing, and possible measures to try to prevent additional incidents; Make any necessary changes in the care plan approaches to any or all of the involved individuals; Document in each resident's clinical record all interventions and their effectiveness; o Residents may only be released from 1:1 supervision once deemed safe by one or a combination of the following: Complete a Report of Incident/Accident form and document the incident, findings, and any corrective measures taken in the resident's medical/clinical record; If, after carefully evaluating the situation, it is determined that care cannot be readily given within the facility, transfer the resident; and Report incidents, findings, and corrective measures to HHSC or other appropriate agencies if indicated as outlined in our facility's abuse reporting policy. Inquiries concerning resident-to-resident altercations should be referred to the Director of Nursing Services or to the Administrator. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	There were no provider investigation reports available for review that involved any of the residents listed in the sample as of 11/26/24. Resident #1 Record Review of Resident #1's face sheet, dated 11/22/24, revealed an [AGE] year-old male that was admitted to the facility on [DATE], with a diagnosis of dementia (memory loss). Record Review of Resident #1's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 00, indicating the resident was severely cognitively impaired. Section E revealed Resident #1 exhibited physical behavior (hitting, kicking, pushing, scratching, grabbing, and abusing) during the review [E0200]. The identified symptoms placed the resident at significant risk for physical illness or injury [E0500]. The identified symptoms placed others at risk for physical injury, significantly intruded on the privacy or activity of others, and significantly disrupted care or living environment. Record review of Resident #1's progress notes dated from 09/22/24- 11/22/24 revealed the following: LVN N documented on 11/10/24 at 11:47 PM that Resident #1 was urinating on the floor and when he was redirected, he hit the certified nurse's aide in the face and began to tear up the air mattress machine in his room. LVN N documented on 11/11/24 at 4:49 PM that Resident #1 continued to go into other residents' rooms hitting on walls and moving closet doors. LVN N documented on 11/11/24 at 5:53 AM that a certified nursing aide (unidentified) and she observed 2 small abrasions approx., 2 cm in size. One was located by his left eye and the other was above his left eye. LVN N documented that it was unknown how Resident #1 received the abrasions. She documented that Resident #1 continued to go into other residents' rooms and when he was redirected, he would lift his hands/arm up as if he was going to hit staff . The Social Worker documented on 11/14/24 at 6:35 PM that she received a message from staff (unidentified) that a staff (unidentified) was punched in the face. LVN N documented on 11/14/24 at 8:30 PM that Resident #1 hit the day certified nursing aide (unidentified) in the face and opened a skin tear on both arms. LVN N documented on 11/14/24 at 8:40 PM that Resident #1 was becoming agitated again, hit a certified nursing aide (unidentified) in the chest. Resident #1 was pacing and yelling in intervals. LVN Q documented on 11/16/24 at 5:45 PM that Resident #1 initiated aggression towards another resident (unidentified) and the resident returned a hit back. She documented that Resident #1 was taken out of the memory unit to calm down. Resident #1 attempted to exit the facility and when staff tried to redirect/intervene he became aggressive. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's care plan, dated 11/22/24, revealed a focused area, initiated on 11/22/24, Resident #1 had a history of aggressive behavior towards others. The goal initiated on 11/22/24, was Resident #1 would have fewer than 3 episodes of aggressive behavior before the next review date. The interventions initiated 11/22/24 included keeping the environment calm, relaxed, convey acceptance of the resident during periods of inappropriate behavior, remove from public area when behavior was unacceptable, and to ask for help when his behavior becomes unacceptable. Record review of the facility event summary report, dated 08/26/24-11/26/24, revealed the following: Resident #1 had aggressive/combative resident-to-resident aggression on 11/16/24 and 2 unwitnessed falls on 11/23/24. Record review of the facility event summary report dated 08/26/24-11/26/24, did not reveal any documentation regarding his resident-to-resident altercation that occurred on 11/14/24 with Resident # 2 and Resident #3 . Record review of Resident #1's hospice progress notes did not reveal any information about Resident #1's and Family Member B's allegation of ANE. There was no information regarding Resident #1's resident-to-resident altercation with Resident #2 (pulling her out if bed). There was no information regarding Resident #1's resident-to-resident altercation with Resident # (grabbing her in her face). The notes did reveal the following: On 11/23/24 at 5:39 AM a call was placed by LVN N to hospice requesting a nurse visit. The progress note indicated that LVN N stated Resident #1 rolled out of bed and had an abrasion to his right eyebrow, a cut on his lip and a skin tear to the bridge of his nose. On 11/23/24 Hospice Nurse T assessed Resident #1. Hospice Nurse T observed Resident #1's nose and lower swollen. She observed steri strips to the face and nose. State surveyor attempted to interview LVN N on 11/27/24 at 8:34 AM and the attempt was unsuccessful. State surveyor left a message. During an interview on 11/26/24 at 9:30 AM, the Regional Nursing Consultant stated during the entrance conference that an injury of unknown origin or bruising should be investigated and reported to HHSC. She said if the bruising could be explained, a progress note would be entered by the nurse who identified the bruising and explain where the bruising came from. She said all efforts would be documented in the resident's electronic medical record . During an interview on 11/26/24 at 10:00 AM, Family Member M stated she was told by facility staff that Resident #1 had told them a nighttime staff had hit him the weekend off 11/23/24 and that she was notified that Resident #1 had a fall. She said she did not know the full name of the staff who reported this information to her nor did she know the name of the staff that allegedly hit Resident #1. She said Resident #1 told her that a woman had hit him. She said the same staff reported that another female resident had hit Resident #1. She said she did not tell anyone specifically about what the facility staff and Resident #1 told her, but that staff knew because she (Family Member M) was vocal about it . (continued on next page)

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	455940	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lubbock Hospitality Nursing and Rehabilitation Cen	4710 Slide Rd Lubbock, TX 79414

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A confidential interview revealed that Resident #1 had a fall the weekend of 11/23/24. They said they could not remember if it was a Friday or a Saturday. They said when they came to work, Resident #1 was quiet and not as active as he once was. They said that Resident #1 gestured with his hand that staff had hit him on top of the head. They asked Resident #1 if it was an overnight staff that had hit him, and Resident #1 stopped answering questions when they started asking for details. They stated Family Member M had expressed in the past that she did not feel that the overnight staff were taking care of Resident #1. They said the weekend that they came in for their shift, and Resident #3 allegedly fell he (Resident #1) did have a cut on his eye and his lip. They said when they attempted to get Resident #1 up for breakfast, Resident #1 was sleepy, and she had to get a wheelchair to roll him to the table. They said they did not know if this was from the fall. They stated that the morning Resident #1 fell , a hospice nurse (unknown) and LVN B were assessing Resident #1. They said the hospice nurse (unknown) said the injuries that Resident #1 sustained were not consistent with a fall. They said that the hospice nurse (unknown) did not say what specifically the injuries looked like they came from. They stated that the same day, Resident #1 did not eat. They said when Resident #1 told them that he had been hit by staff, they told CNA A. They said CNA A told them the injuries looked like injuries from a fall, and CNA compared Resident #1 to another resident with a similar fall. They said that Family Member M told them that Resident #1 had expressed to her that he had been hit by night staff. They said that they did not report the allegations that Resident #1 reported to them nor the concerns that Family Member M reported to them because their phone was not working. They stated they did not use the facility phone because the on-call staff never answered the phone when they called from the facility phone. They said the previous day, they had tried to call the on-call phone from the facility for a staffing concern, and the staff did not answer. They said they had been trained to call the ADM, who was the abuse coordinator if they witnessed or suspected ANE. They said they had been taught to contact the abuse coordinator immediately. They said that they did not contact the ADM, who was the abuse coordinator, because it was the weekend. They said they could not remember if they reported the allegations of ANE to LVN B, but the nurse typically does not stay in the locked unit. They said they did mention the accusations of ANE regarding Resident #1 to the Assistant Activity Director. They said no one had asked them anything about the nature of the fall . During an interview on 11/26/24 at 3:06 PM, CNA A stated that she did not know much about the fall that occurred on 11/23/24 involving Resident #1. They said CNA O told her that Resident #1 had an unwitnessed fall when she came on shift. She said CNA O told her that LVN N was helping her do rounds and change residents. She said CNA O said that she and LVN N had come out of Resident #1's room, and he had fallen. CNA A said she did not remember a staff member telling her that Family Member M had concerns about the injuries, but that Family Member M did express to her that she had concerns about the injuries that Resident #1 sustained. CNA A said that when Family Member M said that she did not think the injuries were consistent with a fall, she encouraged Family Member M to talk to LVN B because as a certified nurse aide she had been trained to refer family concerns to her nurse. CNA A said Resident #1's face was beat up. She said Resident #1 had steri-strips (reinforces skin closure) all over his face. She said he had a busted lip and a cut by his eye. CNA A said she was unaware of Resident #1 having any physical altercations with female residents where he was not the aggressor. CNA A said Resident #1 was aggressive, and all staff knew about it, which had been reported to management. CNA A said Resident #1 had punched her in the face. She said she could not remember the exact date but that it was documented in Resident #1's progress notes. She said they did not receive any instructions on handling Resident #1. She said she felt if his behaviors had been addressed, his behaviors wouldn't have continued to escalate. She said no one had interviewed her regarding Resident #1's behaviors or Family Member M's allegations. CNA said that she had been trained to report ANE as soon as possible to the ADM. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/26/24 at 3:55 PM, the Assistant Activity Director stated that she had experience with Resident #1 and his aggressive behavior. She said when Resident #1 had his resident-to-resident altercation on 11/16/24, she was assisting taking him out of the memory unit to calm down. She said Resident #1 saw an exit door and attempted to exit. She said she tried to redirect him, but he grabbed her hair and pulled it. She said they ultimately got him back to the unit. She said that Resident #1 punched another staff member in the face before that incident. She said she had not received any training specific to Resident #1 on responding to his aggressive behaviors. She said on Saturday, 11/23/24, she went into the memory unit and noticed Resident #1 was at the dining room table with his head down. She thought this was odd because Resident #1 was usually up and pacing around. She said CNA P told her that Resident #1 had fallen. She said she had asked if Family Member M had been notified and was told that attempts had been made, but they were unsuccessful because Family Member M's phone was off. The Assistant Activity Director said that later in the day (11/23/24), Family Member M came to the facility and said to her that Resident #1 reported to her (Family Member M) that someone came into his room at night and hit him. She said it was around lunchtime when she (Family Member M) told her that Resident #1 made the allegation. The Assistant Activity Director stated she told the aides (she did not disclose who) that were working the memory unit and that the aides said that it looked like someone hit Resident #1. She said she told the aides to get a nurse to explain Resident #1's injuries to Family Member M. She said the nurse (LVN B) told Family Member M it was a fall, and it was documented. The Assistant Activity Director told LVN B that Family Member M thought someone had beaten Resident #1 up. She was told that the documentation reflected that Resident #1 had a fall. The Assistant Activity Director said the abuse coordinator was the SW. She said she did not report the allegations of abuse to the SW because the SW was not at the facility. She said she had been trained on what to do if they suspect or witnessed abuse. She said that she had been taught to call the ADM. She said that she did not report the allegations of ANE to the ADM because she was not there when the incident allegedly happened. She said no one had interviewed her to ask her about her knowledge of the incident regarding allegations of abuse. She said she was unaware of any physical altercations that involved Resident #1. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/26/24 at 8:20 PM , LVN B stated the abuse coordinator was the ADM. She stated she had ANE training. She said she had been trained that if she witnessed or suspected abuse, she needed to report the allegation to the ADM as soon as possible. She said that on the day (11/23/24), Resident #1 fell on the overnight shift. He had also fallen on her shift (a day shift). She said CNA A said that she had found Resident #1 on the floor. She said she assessed Resident #1 and called Hospice out for assistance. She said she notified Family Member M. Family Member M was upset because Resident #1 had fallen on the overnight shift. LVN B said it was around 1:00 PM when Resident #1 had fallen on her shift. LVN B said she did not have details about Resident #1's first fall. She said Family Member M was upset. She said that she could tell by her body language but that she was speaking in Spanish to CNA A. LVN B said it was relayed to her from CNA A that Family Member M did not believe the lacerations, cuts, and gashes had come from a fall and that he looked like he had been punched. She said Resident #1 had a history of falls. LVN B said she did not report the allegations that CNA A had translated from Family Member B to the ADM because Family Member B was concerned with the overnight fall. She (LVN B) was sure that Resident #1 did not get punched on her shift, and that Family Member M said she would take Resident #1 home. She said that she was told that Resident #1 had a history of falls, according to the hospice nurse who came out and was not sure why Resident #1's falling was an issue. LVN B said she was unaware that Resident #1 had any physical altercations with female residents in the locked unit. She said Resident #1 never said he had been hit by staff when she interacted with him. She said she was unaware of any incidents that involved Resident #1 and other female residents. She said that since his admission, she had never received any training on how to deal with Resident #1's aggressive behavior. She said she had never been interviewed regarding Resident #1's behaviors or the allegations of ANE. She said the potential negative outcome of not reporting allegations of ANE to the abuse coordinator was that the abuse could continue. She said Resident #1 had told her that he fell . She said she documented what happened during her shift but did not document the information regarding Family Member M because she knew no one punched Resident #1 on her shift. She said that although it may sound silly, she felt that Family Member M wanted to take Resident #1. During an interview on 11/26/24 at 8:25 AM, Hospice Nurse S did not provide any information that supports the facility's deficient practice. She reported that she did not have any concerns with staff treatment, nor did she suspect or witness ANE. She was unaware of any allegations that Family Member M made. She said that she was the nurse who came out when he had behaviors on 11/14/24. She said there were discussions to send him to a behavioral center, but it was decided and, in her opinion, not beneficial for Resident #1 because of his diagnosis of dementia. She said she never said that his injuries were inconsistent with a fall. During an interview on 11/26/24 at 8:38 AM, Hospice Nurse T did not provide any information that supports the facility's deficient practice. She reported that she did not have any concerns with staff treatment, nor did she suspect or witness ANE. She was unaware of any allegations that Family Member M made. She said she came out on 11/23/24 when Resident #1 had his 2nd fall; this was her first time meeting Resident #1. She said that she never expressed that she felt that Resident #1's injuries were inconsistent with any of his falls. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/27/24 at 9:30 AM, CNA C stated that she did not know any details about Resident #1's fall on 11/23/24. She said she heard about Resident #1 punching CNA A but knew nothing about that incident. She said she knew that Resident #1 had been aggressive since he came to the facility. She said she heard that Resident #1 had a broken nose and that someone had been hitting him on top of the head. She said she heard it was a nighttime staff that was hitting him. She said she was told this on 11/26/24 by CNA A. She said she did not report what CNA A told her to the abuse coordinator because she was told that it had already been reported to the state. She said she had no proof that the allegation of ANE had been reported but was told that was why the state was in the facility. She said she had been trained that all allegations of abuse should be reported to the abuse coordinator as soon as possible. She said she received abuse training within the last year when she took her CNA classes. She said the potential negative outcome of not reporting allegations of abuse could allow abuse to continue. During an interview on 11/27/24 at 9:23 AM, the ADM stated he was unaware of Family Member M's allegations of abuse. He said none of the incidents were investigated because he was unaware of the incidents. Preventive measures were not put in place to protect Resident #1 after the allegations of abuse because he was unaware of the incident. He was unaware that Resident #1 had aggressive behaviors before admission. He said that there were discussions about sending Resident #1 to a behavior facility, but after consulting with Hospice, it was recommended by Hospice that pharmaceutical attempts should be taken first. Regarding the injury of unknown origin, he said he was unaware of the injury and that the staff did not know where it came from. He said this was not reported to him. Resident #2 Record Review of Resident #2's face sheet, dated 11/27/24, revealed an [AGE] year-old female that was init [TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours if the alleged violation involved abuse or neglect and resulted in bodily injury, to other officials (including the State Agency) and the Abuse Coordinator for 3 of 6 residents (Resident #1, #2, and #3) reviewed for abuse. A. The ADM failed to follow the facility's abuse policy by not reporting the allegation of abuse to HHSC regarding Resident #1 being hit by an unknown nighttime staff on 11/23/24. B. The ADM failed to follow the facility's abuse policy by not reporting the resident-to-resident altercation (Resident #1 attempted to pull Resident #2 out of bed) that occurred on 11/14/24 between Resident #1 and Resident #2 to HHSC. C. The ADM failed to follow the facility's abuse policy by not reporting the resident-to-resident altercation (Resident #1 grabbed Resident #3 in the face) that occurred on 11/14/24 between Resident #1 and Resident #3 to HHSC. D. CNA A, C, the Assistant Activity Director, LVN B, and a confidential individual failed to follow the facility's abuse policy by not reporting the allegation of abuse involving Resident #1, reported by Resident #1 and Family Member M on 11/23/24 to the abuse preventionist between the dates of 11/23/24-11/27/24. E. The ADM failed to follow the facility's abuse policy by not reporting to HHSC and investigating an injury of an unknown origin involving Resident #1 that occurred and that was documented on 11/11/24. These failures could place residents as risk for abuse and neglect. Findings included: Resident #1 Record Review of Resident #1's face sheet, dated 11/22/24, revealed a [AGE] year-old male that was admitted to the facility on [DATE], with a diagnosis of dementia (memory loss). Record Review of Resident #1's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 00, indicating the resident was severely cognitively impaired. Section E revealed Resident #1 exhibited physical behavior (hitting, kicking, pushing, scratching, grabbing, and abusing) during the review period [E0200]. The identified symptoms placed the resident at significant risk for physical illness or injury [E0500]. The identified symptoms placed others at risk for physical injury, significantly intruded on the privacy or activity of others, and significantly disrupted care or living environment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's progress notes dated from 09/22/24- 11/22/24 revealed the following: LVN N documented on 11/11/24 at 5:53 AM that a certified nursing aide (unidentified) and she observed 2 small abrasions approx., 2 cm in size. One was located by his left eye and the other was above his left eye. LVN N documented that it was unknown how Resident #1 received the abrasions. She documented that Resident #1 continues to go into other residents rooms and when he was redirected he would lift his hands/arm up as if he was going to hit staff. Record review of Resident #1's care plan, dated 11/22/24, revealed a focused area, initiated on 11/22/24, Resident #1 had a history of aggressive behavior towards others. The goal initiated on 11/22/24, was Resident #1 would have fewer than 3 episodes of aggressive behavior before the next review date. The interventions initiated 11/22/24 included keeping the environment calm, relaxed, convey acceptance of the resident during periods of inappropriate behavior, remove from public area when behavior was unacceptable, and to ask for help when his behavior becomes unacceptable. Record review of the facility event summary report, dated 08/26/24-11/26/24, revealed the following: Resident #1 had aggressive/combative resident to resident aggression on 11/23/24 and 2 unwitnessed falls on 11/14/24. Record review of the facility event summary report dated 08/26/24-11/26/24, did not reveal any documentation regarding his resident-resident altercation that occurred on 11/14/24 with Resident # 2 and Resident #3. Record review of the admission/discharge report, dated 08/25/24-11/27/24, revealed Resident # 1 was discharged and return was not anticipated on 11/25/24. Record review of Resident #1's hospice progress notes did not reveal any information about Resident #1's and Family Member B's allegation of ANE. There was no information regarding Resident #1's resident-to-resident altercation with Resident #2 (pulling her out if bed). There was no information regarding Resident #1's resident-to-resident altercation with Resident # (grabbing her in her face). The notes did reveal the following: On 11/23/24 at 5:39 AM a call was placed by LVN N to hospice requesting a nurse visit. The progress note indicated that LVN N stated Resident #1 rolled out of bed and had an abrasion to his right eyebrow, a cut on his lip and a skin tear to the bridge of his nose. On 11/23/24 Hospice Nurse T assessed Resident #1. Hospice Nurse T observed Resident #1's nose and lower swollen. She observed steri strips to the face and nose. State surveyor attempted to interview LVN N on 11/27/24 at 8:34 AM and the attempt was unsuccessful. State surveyor left a message. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/26/24 at 10:00 AM, Family Member M stated she was told by facility staff that Resident #1 had told them a nighttime staff had hit him the weekend (11/23/24) and that she was notified that Resident #1 had a fall. She said she did not know the full name of the staff who reported this information to her nor did she know the name of the staff that allegedly hit Resident #1. She said Resident #1 told her that a woman had hit him. She said the same staff reported that another female resident had hit Resident #1. She said she did not tell anyone specifically about what the facility staff and Resident #1 told her, but that staff knew because she (Family Member M) was vocal about it. A confidential interview revealed that Resident #1 had a fall the weekend of 11/23/24. They said they could not remember if it was a Friday or a Saturday. They said when they came to work, Resident #1 was quiet and not as active as he once was. They said that Resident #1 gestured with his hand that staff had hit him on top of the head. They asked Resident #1 if it was an overnight staff that had hit him, and Resident #1 stopped answering questions when they started asking for details. They stated Family Member M had expressed in the past that she did not feel that the overnight staff were taking care of Resident #1. They said the weekend that they came in for their shift, and Resident #3 allegedly fell he (Resident #1) did have a cut on his eye and his lip. They said when they attempted to get Resident #1 up for breakfast, Resident #1 was sleepy, and she had to get a wheelchair to roll him to the table. They said they did not know if this was from the fall. They stated that the morning Resident #1 fell , a hospice nurse (unknown) and LVN B were assessing Resident #1. They said the hospice nurse (unknown) said the injuries that Resident #1 sustained were not consistent with a fall. They said that the hospice nurse (unknown) did not say what specifically the injuries looked like they came from. They stated that the same day, Resident #1 did not eat. They said when Resident #1 told them that he had been hit by staff, they told CNA A. They said CNA A told them the injuries looked like injuries from a fall, and CNA compared Resident #1 to another resident with a similar fall. They said that Family Member M told them that Resident #1 had expressed to her that he had been hit by night staff. They said that they did not report the allegations that Resident #1 reported to them nor the concerns that Family Member M reported to them because their phone was not working. They stated they did not use the facility phone because the on-call staff never answered the phone when they called from the facility phone. They said the previous day, they had tried to call the on-call phone from the facility for a staffing concern, and the staff did not answer. They said they had been trained to call the ADM, who was the abuse coordinator if they witnessed or suspected ANE. They said they had been taught to contact the abuse coordinator immediately. They said that they did not contact the ADM, who was the abuse coordinator, because it was the weekend. They said they could not remember if they reported the allegations of ANE to LVN B, but the nurse typically does not stay in the locked unit. They said they did mention the accusations of ANE regarding Resident #1 to the Assistant Activity Director. They said no one had asked them anything about the nature of the fall. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/26/24 at 3:06 PM, CNA A stated that she did not know much about the fall that occurred on 11/23/24 involving Resident #1. They said CNA O told her that Resident #1 had an unwitnessed fall when she came on shift. She said CNA O told her that LVN N was helping her do rounds and change residents. She said CNA O said that she and LVN N had come out of Resident #1's room, and he had fallen. CNA A said she did not remember a staff member telling her that Family Member M had concerns about the injuries but that Family Member M did express to her that she had concerns about the injuries that Resident #1 sustained. CNA A said that when Family Member M said that she did not think the injuries were consistent with a fall, she encouraged Family Member M to talk to LVN B because as a certified nurse aide she had been trained to refer family concerns to her nurse. CNA A said Resident #1's face was beat up. She said Resident #1 had steri-strips (reinforces skin closure) all over his face. She said he had a busted lip and a cut by his eye. CNA A said she was unaware of Resident #1 having any physical altercations with female residents where he was not the aggressor. CNA A said Resident #1 was aggressive, and all staff knew about it, which had been reported to management. During an interview on 11/26/24 at 3:55 PM, the Assistant Activity Director stated that she had experience with Resident #1 and his aggressive behavior. She said when Resident #1 had his resident-to-resident altercation on 11/16/24, she was assisting taking him out of the memory unit to calm down. She said on Saturday, 11/23/24, she went into the memory unit and noticed Resident #1 was at the dining room table with his head down. She thought this was odd because Resident #1 was usually up and pacing around. She said CNA P told her that Resident #1 had fallen. She said she had asked if Family Member M had been notified and was told that attempts had been made, but they were unsuccessful because Family Member M's phone was off. The Assistant Activity Director said that later in the day (11/23/24), Family Member M came to the facility and said to her that Resident #1 reported to her (Family Member M) that someone came into his room at night and hit him. She said it was around lunchtime when she (Family Member M) told her that Resident # made the allegation. The Assistant Activity Director stated she told the aides (she did not disclose who) that were working the memory unit and that the aides said that it looked like someone hit Resident #1. She said she told the aides to get a nurse to explain Resident #1's injuries to Family Member M. She said the nurse (LVN B) told Family Member M it was a fall and it was documented. The Assistant Activity Director told LVN B that Family Member M thought someone had beaten Resident #1 up. She was told that the documentation reflected that Resident #1 had a fall. The Assistant Activity Director said the abuse coordinator was the SW. She said she did not report the allegations of abuse to the SW because the SW was not at the facility. She said she had been trained on what to do if they suspect or witnessed abuse. She said that she had been taught to call the ADM. She said that she did not report the allegations of ANE to the ADM because she was not there when the incident allegedly happened. She said no one had interviewed her to ask her about her knowledge of the incident regarding allegations of abuse. She said she was unaware of any physical altercations that involved Resident #1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455940	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lubbock Hospitality Nursing and Rehabilitation Cen	4710 Slide Rd Lubbock, TX 79414

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/26/24 at 8:20 PM, LVN B stated the abuse coordinator was the ADM. She said that on the day (11/23/24), Resident #1 fell on the overnight shift. He had also fallen on her shift (day shift). She said CNA A said that she had found Resident #1 on the floor. She said she assessed Resident #1 and called Hospice out for assistance. She said she notified Family Member M. Family Member M was upset because Resident #1 had fallen on the overnight shift. LVN B said it was around 1:00 PM when Resident #1 had fallen on her shift. LVN B said she did not have details about Resident #1's first fall. She said Family Member M was upset. She said that she could tell by her body language but that she was speaking in Spanish to CNA A. LVN B said it was relayed to her from CNA A that Family Member M did not believe the lacerations, cuts, and gashes had come from a fall and that he looked like he had been punched. She said Resident #1 had a history of falls. LVN B said she did not report the allegations that CNA A had translated from Family Member B to the ADM because Family Member B was concerned with the overnight fall. She (LVN B) was sure that Resident #1 did not get punched on her shift, and that Family Member M also said she would take Resident #1 home. During an interview on 11/27/24 at 9:30 AM, CNA C stated that she did not know any details about Resident #1's fall on 11/23/24. She said she heard about Resident #1 punching CNA A but knew nothing about that incident. She said she knew that Resident #1 had been aggressive since he came to the facility. She said she heard that Resident #1 had a broken nose and that someone had been hitting him on top of the head. She said she heard it was a nighttime staff that was hitting him. She said she was told this on 11/26/24 by CNA A. She said she did not report what CNA A told her to the abuse coordinator because she was told that it had already been reported to the state. She said she had no proof that the allegation of ANE had been reported but was told that was why the state was in the facility. She said she had been trained that all allegations of abuse should be reported to the abuse coordinator as soon as possible. She said she received abuse training within the last year when she took her CNA classes. She said the potential negative outcome of not reporting allegations of abuse could allow abuse to continue. During an interview on 11/27/24 at 9:23 AM, the ADM stated he was unaware of Family Member M's allegations of abuse. Resident #2 Record Review of Resident #2's face sheet, dated 11/27/24, revealed a [AGE] year-old female that was initially admitted to the facility on [DATE] and readmitted on [DATE], with the following diagnoses: dementia (memory loss), anxiety (increased worry) and cognitive communication (difficulty communicating). Record Review of Resident #2's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score was blank. Section E did not reveal any documented behaviors for Resident #2. Record Review of Resident #2's Brief Interview for Mental Status (BIMS) dated 11/27/24 revealed the summary score was 99, indicating the resident was severely cognitively impaired. Record Review of Resident #2's Quarterly MDS assessment dated [DATE], revealed under Section E did not reveal any documented behaviors for Resident #2. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's care plan, dated 08/22/24, revealed a focused area, initiated on 10/01/24, that indicated Resident #2 had socially inappropriate/disruptive behaviors as evidenced by abusing the staff. The goal initiated on 10/31/24 Resident #2 will not harm self or others. The interventions initiated 10/01/24 included assessing the resident for placement, assess whether the behavior endangers the resident and others, avoid over stimulation, praise for acceptable behavior and maintain a calm environment. Record review of Resident #2's progress notes dated from 08/27/24- 11/27/24 did not reveal any information regarding her resident-to-resident altercation on 11/14/24 with Resident #1. Record review of the facility event summary report dated 08/26/24-11/26/24, did not reveal any documentation regarding his resident-to-resident altercation that occurred on 11/14/24 with Resident #2 and Resident #1. During an interview on 11/26/24 at 3:06 PM, CNA A stated she said she heard Resident #2 yelling. When she walked into Resident #2's room, she observed Resident #1 attempting to pull Resident #2 out of bed. She said Resident #2's bed was lowered to the floor with a bedside mat next to it. She said she observed Resident #1 standing on the mat next to Resident #2's bed, and he had her by her (Resident #2) legs. CNA said that Resident #2 was screaming, and Resident #1 was accusing them (staff) of restraining Resident #2 and that he would call the police. She said that on the same date that Resident #1 hit her he also tried to pull Resident #2 out of bed. She said she told the ADM that Resident #1 and the other residents in the locked unit were not safe. She said she did tell the ADM about Resident #1 hitting her and pulling Resident #2 out of bed. During an interview on 11/27/24 at 9:30 AM, CNA C stated that she said she knew that Resident #1 had been aggressive since he came to the facility. She said she did not see the incident but had heard about Resident #1 trying to pull Resident #2 out of bed because he thought she (Resident #2) shouldn't have been in bed. She was unsure of the date of the incident. CNA C said she was unaware if Resident #1 actually made contact with Resident #2. She said no one ever interviewed or asked about the resident-to-resident altercation between Resident #1 and Resident #2. During an interview on 11/27/24 at 9:23 AM, the ADM stated he was unaware of an incident where Resident #1 tried to pull Resident #2 out of bed. He said none of the incidents were reported to HHSC because he was unaware of the incidents. During an interview on 11/27/24 at 1:05 PM, Resident #2 was unable to answer any questions about the alleged incident between her and Resident #1. She turned her head and refused to speak. Resident #3 Record Review of Resident #3's face sheet, dated 11/27/24, revealed a [AGE] year-old female that was initially admitted to the facility on [DATE] and readmitted on [DATE], with a diagnosis of dementia (memory loss), anxiety (increased worry) and cognitive communication deficit (difficulty communicating). Record Review of Resident #3's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 03, indicating the resident was severely cognitively impaired. Section E did not reveal any documented behaviors for Resident #3. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's progress notes dated from 08/27/24- 11/27/24 did not reveal any information regarding her resident-to-resident altercation on 11/14/24 with Resident #1. Record review of Resident #3's care plan, dated 06/12/24, revealed a focused area, initiated on 10/01/24, Resident #3 had physically abusive behavior symptoms. The goal initiated on 11/06/24, was Resident #3 would not physically abuse other residents, visitors, and staff. The interventions initiated 10/01/24 included assess whether the resident's behavior endangers the resident or others, convey an attitude of acceptance towards the resident, maintain a calm environment, and allow extra time to process information. Record review of the facility event summary report dated 08/26/24-11/26/24, did not reveal any documentation regarding his resident-resident altercation that occurred on 11/14/24 with Resident #1. During an interview on 11/26/24 at 3:06 PM, CNA A stated Resident #1 had punched her in the face. She said that on the same date that Resident #1 hit her in the face, he grabbed Resident #3 in the face. She said the ADM and the SW were present when Resident #1 grabbed Resident #3 in the face. She said Resident #1 did it so fast that she could not intervene. She said Resident #3 exclaimed, Why did he do that?. She said the Former DON wanted to send Resident #1 to a behavior center but was told by the ADM that they wanted to try other things. She said she told the ADM that Resident #1 and the other residents in the locked unit were not safe. She said she did not tell the ADM about Resident #1 grabbing Resident #3 in the face because he was present when Resident #1 grabbed Resident #3 in the face. CNA A said she was unsure if a nurse physically assessed any of the residents because she was told to go home and leave. During an interview on 11/27/24 at 9:23 AM, the ADM stated he said he was unaware of an incident where Resident #1 grabbed Resident #3 in the face. He said none of the incidents were reported because he was unaware of the incidents. During an interview on 11/27/24 at 1:17 PM, Resident #3 stated she could not remember the date or the name of the male resident who grabbed her in the face. She said it hurt. She said that the male resident was no longer in the facility, and she was glad because him grabbing her scared her. She said she did not know why he grabbed her, but he was mean. During an interview on 11/27/24 at 9:23 AM, the ADM stated that regarding resident-to-resident altercations, he expected staff to immediately notify the abuse coordinator. He said the potential negative outcome was that if steps were missed or done out of order, something could happen to the residents, or escalate the incidents. He said not reporting resident-to-resident altercations or handling them appropriately could cause an inability for barriers and interventions to be put in place to protect residents. He said if an incident occurs on the weekend, the staff should respond the same. He said there was an on-call system that staff have been trained to use, but unfortunately, the phone was with a staff that no longer worked at the facility. He said the on-call telephone had just been returned to the facility on [DATE]. He said his phone number was posted everywhere, so staff still should be able to reach him, and he would answer phone calls from the facility. He said staff have been trained to send a text and to keep calling if they do not get an answer. He said he had no documentation to reflect the staff training to keep calling if they do not get an answer. He said he verbalized this in an ANE training. He said he was the abuse coordinator, and all things (allegations of ANE and resident-to-resident altercations) should be reported to him within an hour or as soon as possible. He said he, as the abuse coordinator, he was responsible for reporting to HHSC. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/09/24 at 10:36 AM, the ADM stated he was trained on 11/27/24 via telephone by the Regional Nurse Consultant because he was out of town. He said he was trained on the abuse prevention program to include resident-to-resident altercations, reporting abuse, self-reporting guidelines, and the expectations listed in the PL-2024-14. He said he felt confident about carrying out his roles in responsibility as they related to ANE, including documentation, assessments of injury of unknown origin, and abuse prevention. The training specified that injuries of unknown origin should be treated as abuse and reported immediately. He said it would then be his responsibility to treat the injury of unknown origin as abuse and initiate the abuse protocol. The training documentation would not have included the specifics, but this was discussed with each staff member. Record review of the facility policy, Abuse Investigation and Reporting, revised October 2023 revealed: Policy Statement The facility will provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. Policy Interpretation and Implementation o Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; and The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. Abuse Prohibition Plan Components III. Identification of Abuse, Neglect and Exploitation The facility will have written procedures to assist staff in identifying the different types of abuse - mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations. VI. Reporting/Response The facility will have written procedures that include: o Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on interviews and record reviews the facility failed to have evidence all allegations of abuse, neglect or mistreatment were thoroughly investigated for 3 of 6 residents (Resident #1, #2, and #3) reviewed for abuse. A. The ADM failed to investigate Resident #1's allegation of abuse made against an unknown nighttime staff on 11/23/24. B. The ADM failed to investigate a resident to resident altercation (Resident #1 attempting to pull Resident #2 out of bed) that occurred on 11/14/24. C. The ADM failed to investigate a resident-to-resident altercation (Resident #1 grabbed Resident #3 in the face) that occurred on 11/14/24. These failures could place residents as risk for abuse and neglect by not investigating allegations of abuse, neglect, exploitation, or mistreatment. Findings included: Resident #1 Record Review of Resident #1's face sheet, dated 11/22/24, revealed an [AGE] year-old male that was admitted to the facility on [DATE], with a diagnosis of dementia (memory loss). Record Review of Resident #1's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 00, indicating the resident was severely cognitively impaired. Section E revealed Resident #1 exhibited physical behavior (hitting, kicking, pushing, scratching, grabbing, abusing). The identified symptoms placed the resident at significant risk for physical illness or injury. The identified symptoms placed others at risk for physical injury, significantly intruded on the privacy or activity of others, and significantly disrupted care or living environment. Record review of Resident #1's care plan, dated 11/22/24, revealed a focused area, initiated on 11/22/24, Resident #1 had a history of aggressive behavior towards others. The goal initiated on 11/22/24, was Resident #1 would have fewer than 3 episodes of aggressive behavior before the next review date. The interventions initiated 11/22/24 included keeping the environment calm, relaxed, convey acceptance of the resident during periods of inappropriate behavior, remove from public area when behavior was unacceptable, and to ask for help when his behavior becomes unacceptable. Record review of the facility event summary report, dated 08/26/24-11/26/24, revealed the following: Resident #1 had an aggressive/combative resident to resident aggression on 11/23/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility event summary report dated 08/26/24-11/26/24, did not reveal any documentation regarding his resident-to-resident altercations that occurred on 11/14/24 with Resident # 2 and Resident #3. Record review of Resident #1's progress notes, dated 09/22/24-11/22/24, did not reveal any progress notes that involved him pulling a resident (Resident #2) out bed or grabbing another resident (Resident #3) in the face on 11/14/24. Record review of the admission/discharge report dated 08/25/24-11/27/24, revealed Resident # 1 was discharged and return was not anticipated on 11/25/24. During an interview on 11/26/24 at 10:00 AM, Family Member M stated she had concerns about Resident #1's stay at the facility. She said she was told by facility staff that Resident #1 had told them a nighttime staff had hit him on the weekend (11/23/24) and that she was notified that Resident #1 had a fall. She said she did not know the full name of the staff who reported this information to her nor did she know the name of the staff that allegedly hit Resident #1. She said Resident #1 told her that a woman had hit him. She said the same staff reported that another female resident had hit Resident #1. She said she did not tell anyone specifically about what the facility staff and Resident #1 told her, but that staff knew because she (Family Member M) was vocal about it. She could not name the staff that were present when she was in the memory unit. A confidential interview revealed that Resident #1 had a fall the weekend of 11/23/24. They said they could not remember if it was a Friday or a Saturday. They said when they came to work, Resident #1 was quiet and not as active as he once was. They said that Resident #1 gestured with his hand that staff had hit him on top of the head. They asked Resident #1 if it was an overnight staff that had hit him, and Resident #1 stopped answering questions when they started asking for details. They stated Family Member M had expressed in the past that she did not feel that the overnight staff were taking care of Resident #1. They said the weekend that they came in for their shift, and Resident #3 allegedly fell he (Resident #1) did have a cut on his eye and his lip. They said they had been trained to call the ADM, who was the abuse coordinator if they witnessed or suspected ANE. They said they had been taught to contact the abuse coordinator immediately. They said that they did not contact the ADM because it was the weekend. They said no one had asked them anything about the nature of the fall. During an interview on 11/26/24 at 3:06 PM, CNA A stated that she did not know much about the fall that occurred on 11/23/24 involving Resident #1. They said CNA O told her that Resident #1 had an unwitnessed fall when she came on shift. She said CNA O told her that LVN N was helping her do rounds and change residents. She said CNA O said that she and LVN N had come out of Resident #1's room, and he had fallen. CNA A said she did not remember a staff member telling her that Family Member M had concerns about the injuries, but that Family Member M did express to her that she had concerns about the injuries that Resident #1 sustained. CNA A said that when Family Member M said that she did not think the injuries were consistent with a fall, she encouraged Family Member M to talk to LVN B because as a certified nurse aide she had been trained to refer family member concerns to her nurse. CNA A said Resident #1's face was beat up. She said Resident #1 had steri-strips (reinforces skin closure) all over his face. She said he had a busted lip and a cut by his eye. She said no one had interviewed her regarding Resident #1's behaviors or Family Member M's allegations. CNA said that she had been trained to report ANE as soon as possible to the ADM. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/26/24 at 3:55 PM, the Assistant Activity Director stated on Saturday, 11/23/24, she went into the memory unit and noticed Resident #1 was at the dining room table with his head down. She thought this was odd because Resident #1 was usually up and pacing around. She said CNA P told her that Resident #1 had fallen. The Assistant Activity Director said that later on in the day (11/23/24), Family Member M came to the facility and said to her that Resident #1 reported to her (Family Member M) that someone came into his room at night and hit him. She said it was around lunchtime when she (Family Member M) told her that Resident # made the allegation. The Assistant Activity Director stated she told the aides (she did not disclose who) that were working the memory unit and that the aides said that it looked like someone hit Resident #1. She said she told the aides to get a nurse to explain Resident #1's injuries to Family Member M. The Assistant Activity Director told LVN B that Family Member M thought someone had beaten Resident #1 up. She said no one had interviewed her to ask her about her knowledge of the incident regarding allegations of abuse. She said she was unaware of any physical altercations that involved Resident #1. During an interview on 11/26/24 at 8:20 PM, LVN B stated on the day (11/23/24), Resident #1 fell on the overnight shift. She said Resident #1 had also fallen on her shift (day shift) . She said CNA A said that she had found Resident #1 on the floor. She said she assessed Resident #1 and called Hospice out for assistance. She said she notified Family Member M. Family Member M was upset because Resident #1 had fallen on the overnight shift. LVN B said it was around 1:00 PM when Resident #1 had fallen on her shift. LVN B said she did not have details about Resident #1's first fall. She said that she could tell by her body language but that she was speaking in Spanish to CNA A. LVN B said it was relayed to her from CNA A that Family Member M did not believe the lacerations, cuts, and gashes had come from a fall but that he looked like he had been punched. LVN B said she was unaware that Resident #1 had any physical altercations with female residents in the locked unit. She said she had never been interviewed regarding Resident #1's behaviors or the allegations of ANE. During an interview on 11/27/24 at 9:30 AM, CNA C stated she heard that Resident #1 had a broken nose and that someone had been hitting him on top of the head. She said she heard it was a nighttime staff that was hitting him. She said she did not know which nighttime staff. She said she was told this on 11/26/24 by CNA A. During an interview on 11/27/24 at 9:23 AM, the ADM stated that regarding resident-to-resident altercations, he expected staff to separate them and ensure the residents were calm and safe. He said they should immediately notify the abuse coordinator. He said the potential negative outcome was that if steps were missed or done out of order, something could happen to the residents or escalate the incidents. He said not reporting resident-to-resident altercations or handling them appropriately could cause an inability for barriers and interventions to be put in place to protect residents. He said if an incident occurs on the weekend, the staff should respond the same. He said the failure to conduct investigations of ANE could prevent them from knowing how something occurred and what occurred and hurt the ability to prevent abuse from happening again. He said prevention measures should be in place. He said that the aggressor should be monitored depending on the situation and that no additional aggressive behavior should be allowed. He said he, as the abuse coordinator, was responsible for investigating and resident protection measures. He said he was unaware of Family Member M's allegations of abuse. He said none of the incidents were investigated because he was unaware of the incidents. Preventive measures were not put in place to protect Resident #1 after the allegations of abuse because he was unaware of the incident. Resident #2 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455940	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lubbock Hospitality Nursing and Rehabilitation Cen	4710 Slide Rd Lubbock, TX 79414

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #2's face sheet, dated 11/27/24, revealed a [AGE] year-old female that was initially admitted to the facility on [DATE] and readmitted on [DATE], with the following diagnoses: dementia (memory loss), anxiety (increased worry) and cognitive communication (difficulty communicating). Record Review of Resident #2's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score was blank. Section E did not reveal any documented behaviors for Resident #2. Record Review of Resident #2's Brief Interview for Mental Status (BIMS) dated 11/27/24 revealed the summary score was 99, indicating the resident was severely cognitively impaired. Record review of Resident #2's care plan, dated 08/22/24, revealed a focused area, initiated on 10/01/24, that indicated Resident #2 had socially inappropriate/disruptive behaviors as evidenced by abusing the staff. The goal initiated on 10/31/24 Resident #2 will not harm self or others. The interventions initiated 10/01/24 included assessing the resident for placement, assess whether the behavior endangers the resident and others, avoid over stimulation, praise for acceptable behavior and maintain a calm environment. Record review of Resident #2's progress notes dated from 08/27/24- 11/27/24 did not reveal any information regarding her resident-to-resident altercation on 11/14/24 with Resident #1. Record review of the facility event summary report dated 08/26/24-11/26/24, did not reveal any documentation regarding his resident-to-resident altercation that occurred on 11/14/24 with Resident #2 and Resident #1. During an interview on 11/26/24 at 3:06 PM, CNA A stated on the same day he punched her in the face, Resident #1 had increased behaviors. She said she heard Resident #2 yelling. When she walked into Resident #2's room, she observed Resident #1 attempting to pull Resident #2 out of bed. She said Resident #2's bed was lowered to the floor with a bedside mat next to it. She said she observed Resident #1 standing on the mat next to Resident #2's bed, and he had her by her (Resident #2) legs. CNA said that Resident #2 was screaming, and Resident #1 was accusing them (staff) of restraining Resident #2 and that he would call the police. CNA A said she attempted to redirect Resident #1, but he tried to hit her. She said she blocked the first hit from Resident #1. She said he then tried to grab the fire extinguisher and said he would hit her. She said Resident #1 grabbed a chair, and because other residents were close, she went to grab the chair from him. She said that when she got the chair from him, and she was putting it down, Resident #1 hit her hard in the face, and she started crying. She said that on the same date that Resident #1 hit her he also tried to pull Resident #2 out of bed. She said the Former DON wanted to send Resident #1 to a behavior center but was told by the ADM that they wanted to try other things. She said she told the ADM that Resident #1 and the other residents in the locked unit were not safe. She said she did tell the ADM about Resident #1 hitting her and pulling Resident #2 out of bed. She said no one had interviewed her regarding Resident #1's behaviors or his interactions with Resident #2. During an interview on 11/27/24 at 9:23 AM, the ADM stated he was unaware of an incident where Resident #1 tried to pull Resident #2 out of bed. He said none of the incidents were investigated because he was unaware of the incidents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/27/24 at 1:05 PM, Resident #2 was unable to answer any questions about the alleged incident between her and Resident #1. She turned her head and refused to speak. Resident #3 Record Review of Resident #3's face sheet, dated 11/27/24, revealed a [AGE] year-old female that was initially admitted to the facility on [DATE] and readmitted on [DATE], with a diagnosis of dementia (memory loss), anxiety (increased worry) and cognitive communication deficit (difficulty communicating). Record Review of Resident #3's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 03, indicating the resident was severely cognitively impaired. Section E did not reveal any documented behaviors for Resident #3. Record review of Resident #3's progress notes dated from 08/27/24- 11/27/24 did not reveal any information regarding her resident-to-resident altercation on 11/14/24 with Resident #1. Record review of Resident #3's care plan, dated 06/12/24, revealed a focused area, initiated on 10/01/24, Resident #3 had physically abusive behavior symptoms. The goal initiated on 11/06/24, was Resident #3 would not physically abuse other residents, visitors, and staff. The interventions initiated 10/01/24 included assess whether the resident's behavior endangers the resident or others, convey an attitude of acceptance towards the resident, maintain a calm environment, and allow extra time to process information. Record review of the facility event summary report dated 08/26/24-11/26/24, did not reveal any documentation regarding his resident-resident altercation that occurred on 11/14/24 with Resident #1. During an interview on 11/26/24 at 3:06 PM, CNA A stated on the same day (12/05/24) he punched her in the face, Resident #1 had increased behaviors. She said that on the same date that Resident #1 hit her in the face, he also grabbed Resident #3 in the face. She said the ADM and bthe SW were present when Resident #1 grabbed Resident #3 in the face. She said Resident #1 did it so fast that she could not intervene. She said Resident #3 exclaimed, Why did he do that?. She said the Former DON wanted to send Resident #1 to a behavior center but was told by the ADM that they wanted to try other things. She said she told the ADM that Resident #1 and the other residents in the locked unit were not safe. She said she did not tell the ADM about Resident #1 grabbing Resident #3 in the face because he was present when Resident #1 grabbed Resident #3 in the face. She said no one had interviewed her regarding Resident #1's behaviors or his interaction with Resident #3. During an interview on 11/27/24 at 9:23 AM, the ADM stated he said he was unaware of an incident where Resident #1 grabbed Resident #3 in the face. He said none of the incidents were investigated because he was unaware of the incidents. During an interview on 11/27/24 at 1:17 PM, Resident #3 stated she could not remember the date or the name of the male resident who grabbed her in the face. She said it hurt. She said that the male resident was no longer in the facility, and she was glad because him grabbing her scared her. She said she did not know why he grabbed her, but he was mean. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy, Abuse Investigation and Reporting, revised October 2023 revealed: Policy Statement The facility will provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. Policy Interpretation and Implementation The facility will develop and implement written policies and procedures that: o Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; and o Establish policies and procedures to investigate any such allegations. IV. Investigation of Alleged Abuse, Neglect and Exploitation An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include: o Identifying staff responsible for the investigation; o Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); o Investigating different types of alleged violations; o Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; o Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and o Providing complete and thorough documentation of the investigation. Record review of the facility policy, Resident-to Resident Altercations, revised October 2023 revealed: Policy Statement All altercations, including those that may represent resident-to-resident abuse, shall be investigated, and reported to the Nursing Supervisor, the Director of Nursing Services and to the Administrator. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Interpretation and Implementation Facility staff will monitor residents for aggressive/inappropriate behavior towards other residents, family members, visitors, or to the staff. Occurrences of such incidents shall be promptly reported to the Nurse Supervisor, Director of Nursing Services, and to the Administrator. If two residents are involved in an altercation, the nursing staff will: a. Separate the residents, and institute measures to calm the situation up to and/or including 1:1 supervision of the offending resident; Identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation;